(3) Programs for coordination of plan services with community and social services generally available through contracting or noncontracting providers in the area served by the M+C plan, including nursing home and community-based services; and

(4) Procedures to ensure that the M+C organization and its provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that—

(i) The M+C organization makes a ''best-effort'' attempt to conduct an initial assessment of each enrollee's health care needs, including following up on unsuccessful attempts to contact an enrollee, within 90 days of the effective date of enrollment;

(ii) Each provider, supplier, and practitioner furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the M+C organization, taking into account professional standards; and

(iii) There is appropriate and confidential exchange of information among provider network components.

(5) Procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and

(6) Systems to address barriers to enrollee compliance with prescribed treatments or regimens.

(c) *Special rules for all M+C organizations for emergency and urgently needed services*—(1) *Coverage.* The M+C organization covers emergency and urgently needed services—

(i) Regardless of whether the services are obtained within or outside the M+C organization; and

(ii) Without required prior authorization.

(2) *Financial responsibility.* The M+C organization may not deny payment for a condition—

(i) That is an emergency medical condition as defined in § 422.2; or

(ii) For which a plan provider or other M+C organization representative instructs an enrollee to seek emergency services within or outside the plan.

(3) *Stabilized condition.* The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the M+C organization.

(4) *Limits on charges to enrollees.* For emergency services obtained outside the M+C plan's provider network, the M+C organization may not charge the enrollee more than $50 or what it would charge the enrollee if he or she obtained the services through the M+C organization, whichever is less.

[64 FR 7980, Feb. 17, 1999]

§ 422.114 Access to services under an M+C private fee-for-service plan.

(a) *Sufficient access.* (1) An M+C organization that offers an M+C private fee-for-service plan must demonstrate to HCFA that it has sufficient number and range of providers willing to furnish services under the plan.

(2) HCFA finds that an M+C organization meets the requirement in paragraph (a)(1) of this section if, with respect to a particular category of health care providers, the M+C organization has—

(i) Payment rates that are not less than the rates that apply under original Medicare for the provider in question;

(ii) Contracts or agreements with a sufficient number and range of providers to furnish the services covered under the M+C private fee-for-service plan; or

(iii) A combination of paragraphs (a)(2)(i) and (a)(2)(ii) of this section.

(b) *Freedom of choice.* M+C fee-for-service plans must permit enrollees to obtain services from any entity that is authorized to provide services under Medicare Part A and Part B and agrees to provide services under the terms of the plan.

§ 422.118 Confidentiality and accuracy of enrollee records.

For any medical records or other health and enrollment information it maintains with respect to enrollees, an M+C organization must establish procedures to do the following:

(a) Safeguard the privacy of any information that identifies a particular enrollee. Information from, or copies